Case 1:04-cv-00246-SOMLSPB Docume Page 1 of 12 NO CA-04-246 ERIE IRNIN PLAINF. F.Y MOTION FOR APPRINTMENT OF COMPUSEL FOR DISCOVER DISTRATION TO CONTINUE ON TO TriAL AND NOW this 2 9th day of December 2006 comes the petitioner Activity pro se And petitions This Norther Court to Appoint Coursel Until metal to help prepare petitioner Avers the following to help prepare 1 plaintiff is in Need of Counsel to help prepare 1 the Case before this Court in 5 train entities of the Case before this Court in 5 train entities. 2 PLAINTIGE IS A LANGUANIN THE STUDY OF LAW AND HAS A DISABILITY, "ADD" That impared His comprehending, And CANNOT UNDERSTAND
How or what to file in this current
Case to beable to Continue on, 3 PLAINTIFF HAS, EVIDENCE, DECLARATIONS AND MUNITIVE RECORDS That if presented Clearun medical Records The WCCF, Deviethin would show that The WCCF, Deviethin would show that In That was Required the medical Attention That was Required the medical Attention That was Required From July 10th to October 17th 2002, From July 10th to October 17th 2002, From July 10th to Prays This Honorable court Physical Plaintion him so that he man proceeding to Appoint courselve December 29 that American December 29 that American MARS University of Pittsburgh Electronic Medical Records System MARS

Name ..... IRWIN CHRISTOPHER D

MRN ..... 202549085 PUH

Physician ...... Ricard Townsend, M.D.

Report Type ..... Discharge Summary

Date of Event .... 07/08/02 Date of Birth .... 03/27/1973

Patient Status ... I

Last Adm Date .... 07/08/02 Last Disch Date .. 07/08/02

SP# ..... 020724113828MEDQUIS3 Authored by ..... Umamahesh Duvvuri, M.D.

Account # ..... 0201851042188

Hosp/Group ..... PUH

WARNING! You must protect this document as confidential medical record information. Please handle, store, and dispose appropriately.

\_\_\_\_\_\_\_

\_\_\_\_

## HISTORY OF PRESENT ILLNESS:

The patient is a 29-year-old male who was an unrestrained driver with a positive ethanol blood level who was involved in a fatality car wreck. He presented to the Emergency Department with C3-C4 tenderness and chest tightness. He also had upper thoracic tenderness in particular. The patient also had a positive test for cocaine, as well as a history of exploratory laparoscopy in the past for a prior gunshot wound.

His workup in the Emergency Department was essentially negative, which included a CT scan of his cervical spine C1 through C2 which was negative. CT scan of head, CT scan of his chest and CT scan of his abdomen were all negative. C-spine series was negative preliminarily. Abdominal x-ray was negative. Chest x-ray was also negative preliminarily. TOS films were also negative. The patient removed his own collar himself before the C-spine was completely cleared medically.

## HOSPITAL COURSE:

The patient had a medical hospital course where his diet was advanced as tolerated. Psychiatry was consulted when the patient complained of having a "nerves" problem. They recommended that he be discharged with a taper of Zoloft leading up to 100 mg p.o. q. day after a course of 20 days taper going from 12.5 up to 100 mg; that was, 12.5 for four days, 25 for four days, 50 at four days, and then 100 mg per day p.o.

The patient also had films of his right and left shoulders to rule out any fractures, and those films were also read as negative.

The patient was seen by Physical Therapy who recommended rehabilitation in both the inpatient and outpatient settings. The patient was discharged with prescription for this.

The patient was discharged from the hospital in stable condition.

Case 1:04-cv-00246-SJM-SPB Document 69 Filed 01//10/2007 Page 3 of 12

DISCHAR GE DIAGNOSIS:

LEVEL T WO TRAUMA.

DISCHAR GE DIET:

The pat ient has a diet that is regular.

# DISCHARGE ACTIVITY:

The patient has no restrictions of walking, sitting, school, work, or sexual activity. The patient was advised not to engage in heavy lifting, driving, or strenuous activity until he had undergone physical therapy.

## DISCHARGE INSTRUCTIONS:

The patient was discharged with instructions to return to clinic should he experience numbness, pain or tingling, or paralysis of his hands or extremities, or for shortness of breath, chest pain, fever, chills, nausea, vomiting, headaches, or other constitutional symptoms not relieved by over-the-counter medications.

Ricard Townsend, M.D.

Dictator: Umamahesh Duvvuri, M.D. Terturi Telegram of the Company of the Company

UD/790

D: 07/08/2002

T: 07/12/2002 11:38

Job #: 22305

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UPMC HEALTI	I System		-		Telegraph (		. :	
PATIENT DISCHARGE MEDICATION SCHEDI	JLE	IONS	DR. TON	CHRIS INSEND 104 21	TOPHER , RICAR 88 07/0	D N GNS	01	
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Signature: $\sqrt{7/asyp}$		Patient/ Significant	Other	PAY	IRW	IN, CHEIST	OPHER	
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Medication Name Dose / Schedule	т	imes to Ta	ke Medicati	ons	; <u>/ (                                  </u>		Side Effect/Food Interaction / Con (If additional to med	nments
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PATIENT OUTCOME FLOWSH Reason for admission	EET							•	-0.	L- <b>J</b>	<b>-+-</b> 8	08	5													
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PSYCHOSOCIAL/MENTAL/EMOTIONAL ASSESSMENT Afte appropriate for situation. Initiates conversion. Makes eye contact appropriate questions about hospitalization, procedures, etc. Ar does not interfere with ability to follow direction. PSN	ct ct. Asks	*	1		0	*																				_
NEUROLOGICAL ASSESSMENT Alert and oriented to person time. Behavior appropriate to situation, Symmetry of strength of extremities. No parathesia. Verbalization clear and understandard	all	*		3	2 -	ی														[						
CARDIOVASCULAR ASSESSMENT Regular pulse. Periphera palpable. No calf tenderness. No claudication. Blood pressure vipatient's normal limits. Afebrile. PSN	l pulses vithin	V	$\prod$		1																					_
RESPIRATORY ASSESSMENT Resp. 10-20/min. @ rest. Repregular. Breath sounds vesicular through both lung fields, bronc major airways with no adventitious sounds. Sputum clear and/o Nailbeds & mucous membranes plnk. PSN	hial over	1	<b>\</b>	,																						
GASTROINTESTINAL ASSESSMENT Abdomen soft, bowel si (5-34/min.) No pain with palpation. Tolgrates prescribed diet with a vomiting. Having stools builting own normal pattern and consist	ounds active hout nausea tency. PSN	,	7	1	1																					
GENITOURINARY ASSESSMENT Able to empty bladder on or difficulty. Urine clear & yellow to amber. No incontinence, dribbl hematuria, dysuria, frequency. PSN	wn without ing,	-4	*	١	4-	,																				_
HEENT ASSESSMENT Face symmetrical. Absence of nasal/educationage. Traches midline. Swallowing without coughing or cho liquids and solids. Does not require assistive devices for vision PSN	king on	Ĵ														·										_
INTEGUMENTARY ASSESSMENT Skin color within patient's i warm, dry & intact. Mucous membranes molst. No skin breakd wound present, is clean, dry & intact with edges well approxima evidence of wound infection. "Pt. NOT at high risk for breakdow at risk or status changes during hospitalization implement meas in Practice Guidelines for Patients at Risk for Skin Breakdown).  Braden Scale Score (To be done PSN)	own, if nted, no m. (if patient sures found	*		,	*	1															15 67 7 20 20 41 7				GY 2013 2014 2014 1014 1016 1016	(3.7) 8.44 9.45 9.43 9.43
MUSCULOSKELETAL ASSESSMENT Absence of joint swelling tenderness. Normal ROM of all joints. No muscle weakness. Su tissues free of erythema or pain. Ambulates without assistance high risk for falls (If patient at risk OR becomes HIGH RISK dur hospitalization implement protective measures found in Practice for Patients at Risk for Falls). PSN	irrounding Pt. NOT at inc	*			<b>b</b> -	4																				
NEUROVASCULAR ASSESSMENT Bilateral extremities are p warm & movable. Capillary refill times < 3 seconds. No edema extremities. Sensation intact without numbness or tingling. PSN	to	V			1																					
VASCULAR ASSESS Insertion site without sins of infection or Catheter patent and dressing intact. Blood return present and fl without difficulty. (If no access - write N/A.) (Periphera site toto 3 days UNLESS extended by an MD order.) PSN	infiltration. ushës echanged q	-	1		1																					<u> </u>
PAIN ASSESSMENT Without pain or experiencing paid that is effectively. PAIN SCORE (Write the score in the box to the righ	t)/	6																								
(no pain) 0 1 2 3 4 5 6 7 8 9 10 (wor	st pain ever)-	10			X	X																				
SPIRITUAL ASSESSMENT Demonstrates ability to cope with hospitalization/treatment and illness in a reasonable manner. E religious needs are being met.	xpressed	۰	1		$\sqrt{}$																					
EDUCATIONAL ASSESSMENT Patient and/or significant othe demonstrate comprehension or patients disease process, treat discharge plans. Asks questions relevant to health process.		~	II		1,																					
INITIALS		<u> </u>	<u>Y</u>	1	V.	V					L_						Ĺ									



Directions: Place a check mark (\*/) in the column corresponding to the system assessment if the patient assessment findings have met the described parameters. Document Patient Specific Normal (PSN) findings on the line provided in each parameter box! PSN = findings that will not change and are baseline for patient. These intelline provided in each patient's normal assessment and will not be noted as abnormal with each assessment. Place an asterisk (\*) in the column if a significant finding is Identified and requires further elaboration in the "Significant Findings" section . An arrow (→) indicates that the status remains unchanged from the previous asterisk entry. Patient will be assessed each shift, with reassessment as necessary.

3256-02-U FORM 4153-0000-0400

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UPMC HEALTH SYSTEM	
DATIENT ACCECCMENT	202 54 9085 FUH G0819 01
PATIENT ASSESSMENT	IRWIN CHRISTOPHER D
	DR. TOWNSEND, RICARD N GNS
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ADMISSION ASSESSMENT COMPLETINGS: RN SIGNATURE:	PRIVATE PAY
	-
INFORMATION OBTAINED FROM:	IMPRINT PATIL IRWIN, CHRISTOPHER
<del></del>	202-54-9085
EDUCATIONAL NEEDS	202
Check any of the following that may serve as a barrier to learning:  ☐ Visual impairment ☐ Hearing impairment ☐ Physical limitations	ns 🗆 Fear/Anxiety 🗘 Learning disability 🗔 Religious beliefs
☐ Cultural/Lifestyle beliefs ☐ Communication ☐ Language (specify	· · · · · · · · · · · · · · · · · · ·
Name of interpreter:	Phone number of interpreter:
If barriers are present, describe methods used to overcome	
What is the easiest way for you to learn? (Check all that apply)	
Printed material Verbal explanation CAudio-tape	Video Demonstration Individual Instruction
☐ Group Instruction ☐ Other	
While you are in the hospital, check the areas that you would like to lea	earn about.
☐ Illness for which you are hospitalized ☐ Signs and symptom	oms of illness
☐ Side effects of medications ☐ Special Diet	☐ Activity Restrictions ☐ Incisional/Wound care
Other	
Other persons requiring these instructions: Name:	Relationship:
What was your highest level of education?	☐ High School
Have you attended any pre-admission classes? ☐ Yes ☐ No	The service of the se
IF YES, Date:Topic:	
Describe your readiness for learning/education:	The grant following is a series of the
Receptive/willing to learn Not able to concentrate	□ Not interested at this time □ Overwhelmed/frightened
PAIN ASSESSMENT	
Do you have pain now?	'
Have you experienced pain in the past week? ☐ Yes ☐ ¶o	
IF "Yes" is answered continue with the following:	Thoulder
	GIGULAUC
Quality (use patient's words to describe)	750
OY III	
Intensity of pain: (select one 0 1 2 3 4 5 6 17 8 9 10)	)
at rest with activity (describe)	,
Onset and duration of pain: STOKE THE OCCIDE	
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A sold and a sold as a sold	- Classia
Associated symptoms:	thospine obligate (describe)?
<b>22</b> (6)	1 / / T
Present pain management regimen: 114 Oy 1070C	A8~
is this regimen enective: Li res Le 140	Daniel Market Colonina
Physical exam/observation of the pain site: LINY/0//S	TOONIAN SUITA ANT IN CONTINU
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140-04-02

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UPMC HEALTH SYSTEM

# PHYSICIAN'S ORDER SHEET

AUTHORIZATION IS GIVEN TO THE PHARMACY TO DISPENSE AND TO THE NURS & TO ADMINISTER THE GENERIC OR CHEMICAL EQUIVALENT WHEN THE DRUG IS FILLED BY THE PHARMACY OF PRESBYTERIAN UNIVERSITY HOSPITAL OR MONTEFIORE UNIVERSITY HOSPITAL - UNLESS THE PRODUCT NAME IS CIRCLED.

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WASHINGTON PA 15301 RUR H
724 225 9144 03/27/73 297
PRIVATE PAY

IRWIN, CHRISTOPHER. 202-54-9085

IMPRINT PATIEN. DATE TIME **ORDERS** Pol 0 00 0031-01-U FORM 1973-4040-0995 ITEM 05245 CHART COPY - THIS MUST REMAIN IN CHART

IRWIN, CHRISTOPHER 202-54-9085

140-04-02

UPMC HEALTH SYSTEM

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PRIVATE PAY

IMPRINT PATIENT IDENTIFICATION PLATE HERE

		IMPRINT PATIENT IDENTIFICATION PLATE HERE
DATE	TIME	ORDERS
7/8/02		D/c to home
		Level 2 Trauma
<del></del> _		Stable
		Arlengies: NKDA
		Activity: as tolerated: of heavy lifting, odriving
		minimize such extremous acturity until follow up.
		Diet: Regular
		Meds: Vioxx 25 mg po @D
	1 1 1	Percocet 5 mg 7-1 tabs. p.o. of 4-6h pro pain
		Arran i my p. e tid.
		26/oft 12.5 mg Po am 1540
		251-ft 25mg Po QAM X4d
		Zolft 50 mg Po QAM X4d
		2010ft 100 mg Po QAM
		Special: Follow up in Clinic as needed
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		and have been a coldinary of bareline
		arn numbres esident or paralysis 003/-01-U FORM 1973-4040-0995 ITEM 05245
		M. Dunni un
		PHYSICIAN: MAKE SURE WHITE COPY  & NUMBER SHOW THROUGH HOLE BEFORE WRITING DRUG ORDER.
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(T) Heart rate (U) On dialysis (V) Infiltrate \*(X) Tubing changed

3266-01-U FORM 4162-0000-1099 ITEM 55008

7/8/02: DIC CILS OVEC . **UPMC HEALTH SYSTEM** NKDA 54 9085 PUH GOBIS 01 Meds rev. PUH OMUH OOTHER: CHRISTOPHER D Adv. Dir : NO DR. ITOWNSEND. RICARD N GNS PHYSICAL THERAPY PRE OR 020185104 2188 07/07/02 POST-OP GAIT ASSESSMENT 787 REGENT DRIVE WASHINGTON PA 15301 RUN H □ Inpatient 724 225 9144 03/27/73 Outpatient Other: PRIVATE PAY DX/PMH/Other: 29 410 03 adn 7/7/02 5 MVC 6) FTDH/coccaine unrestained driver. Ofatality in accident). IMPRINT PATIENT IDENTIFICATION HERE Physician Orders: PIloT 7/8/02 SUBJECTIVE Home Situation: & family, mom @ Shrs/day 7days/wk (1) PTA. mobile home 35TE & rail Referring Physician: ilicq. atm: Townsond Prior use of crutches: ☐ Yes □ No N/AP Ø C/O's pain: Yes No Location: B should ers chest MENTAL STATUS INSPECTION \*PREC\* ? Smoulder fx (P) → flione MD to chick?" suff 13500 Us \*\* (B) should its ( 1) Alem. PMH: GSW to abdomen sto laparotomy oriented to: Aperson Aplace Atime Acooperative VITALS: HR 78 68 148190 1177 74 BF 168184 aware of dx: ☑ Yes □ No □ N/A sansation: NO gross defizits to note to It touch the xyext. aware of prognosis: □ No □ N/A able to follow 1 step commands: ☑ Yes □ No □ N/A COM: POOR UES WPL BLE Inspect: unremarkable - tagal laceration. RANGE OF MOTION Uninvolved Extremities: BUE WELC ARONA 110 F EXCLOSION TO BIL UF @ Shoulders Minimal AROM B Opain Quesettian @ NNL to BLE T AROM. Uninvolved Extremities: \_ ≥3/5 1/0 ×46×1 & Oxception to Boharden mon groups Involved Extremities: FUNCTIONAL Comments (Gait Deviations): Rigid goit Stightly unsteady bed mob: Min @ Transfers sup wsit: mod € Iskpi length velocity &S. Fair @ gait sequencing -Sit to stand 1 SHP CS MOD MAX N/A N/AP -Wheelchair to mat I SUP CS MOD MAX OUE swing Arms quarded 20 shoulders thest pain. N/AP -Wheelchair to bed I SUP MOD MAX WAP Ambulation -Level SUP CS (MIN) MOD MAX N/A N/AP -Stairs Patient given crutches: SUP CS MIN MOD C Yes No MAX (VA) N/AP -Ramps SUP Patient given home instructions: [] Yes CS MIN MOD MAX N/A (K/AB) UE gaurded + 11051 Ass't. Device: Education: PT ROLL POC DICRE SARRY Distance:.. WB Status: FWB B LE NWB TDWB PWB WBAT Other: PT Problems: + transfers & gait 1 pain + UE from mobility DIC REC: Short acute cenals Stay
ASSESSMENT: PROBLEMS AND GOALS AND PLAN OF CARE Goal of independent gait training achieved, PT d/c'd O comments: It to be seen OD SXIWK to max (1) for DIC to home to short remain stay. STBs (lwk) O (3) & hed mob. @ Min(A) = Sup & Sit @ (S) = GIT & Stand . ED Lumb > 200' S(D) (S) 1 Shoulder Mean (B) to WFL . (C) & pain 40 LTOS: PLUFIED t-goal: "I can't go have I want to stay I more day!" Physical Therapist Signature: Date: 7/8/02 Pager no: PHYSICAL THERAPY PRE OR POST-OP GAIT ASSESSMENT (See abbreviations on back) 0275-01-11 FORM 1188-3440-0298

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UPMC HEALTH SYSTEM	X.PUH   SSH   MUH   BDK   WPIC   BVH   OTHER	20	2 54 9085 P	Page 3 of 3
OCCUPATIONAL THERAPY ASSES	SMENT	IRI DR	IIN, CHRISTOPHER TOWNSEND, RICA	D RD N GNS
OT indicated: ON x per day, LOS days	week	787	HINGTON PA 153	OI RUN H
☐ No further OT services indicated			VATE PAY	/73 298
	☐ poor			
Treatment:  Independent Living/Daily Living Skills	☐ Muscle Re-ed	lucation	IRWIN, CHRISTO 202-54-908	
☐ Fine Motor Coordination ☐ Orthotics/Splinting ☑ Patient/Family Education	☐ Neuro-Develo  CAdaptive Equi  Cognitive Re-	pment PU	ent 🖂 Senso	ory Treatment onmental Modifications
Long Term Goals: by				
Improve level of function for following ADL:  Feeding  UE Dressing  UE Dressing		<ul><li>☐ Simple Meal</li><li>☐ Cleaning/Hor</li></ul>	function for following IADL: Preparation Tasks ne Management	
☐ Toileting ☐ Bathing ☐ Sit to Stand Transfer ☐ Bed/Chair ☐	sfer 🗆 1	Provide adaptiv		ROM AROM /5 Strength
☐ Tollet Transfers ☐ Tub Transfers ☐ Improve Safety Awareness ☐ Independence with home program ☐ Tub Transfers ☐ Tub Transfer		Recommend us	e of: ☐ Tub seat/bench ☐ Bedside commode	☐ Grab bars ☐ Elevated toilet seat
	-			<u> </u>
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Short Term Goals: by pt. w	in Diak	U 116	).	
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☐ Demonstrate ☐ Max ☐ Mod ☐ M ☐ Demonstrate ☐ Max ☐ Mod ☐ M			•	Dressing
☐ Demonstrate ☐ Max ☐ Mod ☐ M				Tolleting Sit/Stand Transfer
☐ Demonstrate ☐ Max ☐ Mod ☐ M				Bed/Chair Transfer
☐ Demonstrate ☐ Max ☐ Mod ☐ M				Toilet Transfer
☐ Demonstrate ☐ Max ☐ Mod ☐ M	n 🗆 Supervisid	n 🗆 Mod		Tub Transfer
☐ Demonstrate awareness of ☐☐ Tolerate ☐☐ 10 minutes ☐☐ 15 minutes ☐☐ 20 ☐☐ Tolerate splint wear without adverse reaction per pos	minutes 30 m	inutes of therap	through pt/family educated activity with rest pe	ation riods.
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O				
Comments:	eal process ( px Yes	□ No		•
A 1881/A BRIN ABINS HERRE STANDARD TO BE AND A HERRE STANDARD FOR AN	1			
		THA	OTR/L DATE_	7-8-02.
1 150010 05070 05110 (1200 1117 (1200) 2015) (121 1200 (1101 1101)	(See abbreviations on	base	WHITE - MEDICAL RECORDS	S COPY CANARY - OT COPY
			0023-01-U FOR	M 2275-2960-0999 ITEM 05324